RECOMMENDED IMMUNIZATIONS FOR HOSPITAL AND MEDICAL OUTPATIENT FACILITY PERSONNEL

Based on the recommendations of the U.S. Public Health Services Advisory Committee on Immunization Practices

Vaccines	Primary Schedule and Booster(s) **	Indications	Major Precautions and Contraindications	Special Considerations
Hepatitis B Inactivated Virus Vaccine	3 doses; 1st two 1-2 months apart and 3rd at least 2 months after the 2nd and at least 4 months after the 1st. No need for boosters.	Personnel who have regular or potential contact with patients' blood or tissue fluids and are not known to be previously infected or immune should be immunized. Can start series with one manufacturer's vaccines and finish with another. Post-exposure prophylaxis: consult USPHS recommendations, local health department, or the Immunization Branch.		• Serologic screening for susceptibility before immunization need not be done unless the hospital considers it cost-effective or a vaccinee requests it. Screening may or may not be cost-effective depending on cost of vaccine and testing and on prevalence of previously infected persons in the group. • 1 month after the 3rd dose, serotesting for anti-HBs seroresponse should be considered.
Influenza Inactivated Virus Vaccine	Annual fall immunization with current vaccine. Dose: 0.5 ml (IM)	Each fall, immunize staff and volunteers who have substantial contact with high-risk patients (e.g., primary-care and certain specialty clinicians; staff of intensive care units, particularly neonatal ICUs; staff caring for the elderly, transplant recipients, and people with AIDS.)	History of anaphylactic hypersensitivity to eggs	
Measles Live Virus Vaccine (usually given as MMR)	2 doses, at least 1 month apart. No booster. Dose: 0.5 ml (SC)	Personnel born in 1957 or later and at risk of contact with patients infected with measles should be considered immune only if they have documented measles seropositivity or documented receipt of two doses of measles vaccine on or after the first birthday. Those born in 1956 or earlier should be considered susceptible unless they have documentation of seropositivity or receipt of one dose of measles vaccine on or after the first birthday. *	Pregnancy, immunocompromised; history of anaphylactic hypersensitivity to egg or neomycin; recent receipt of immune globulin or blood/blood product.	MMR is the vaccine of choice if recipients possibly are susceptible to rubella and/or mumps as well.
Rubella Live Virus Vaccine (usually given as MMR)	1 dose. No booster. Dose: 0.5 ml (SC)	All personnel, both male and female, considered to be at risk of contact with patients with rubella or who are likely to have contact with pregnant patients should be immune to rubella . * Before immunizing, serologic screening for rubella can be done if the hospital considers it cost-effective or the potential vaccinee requests it. Persons lacking documentation of vaccine on or after 1st birthday or laboratory evidence of immunity should be considered susceptible.	Pregnancy; immunocompromised; history of anaphylactic hypersensitivity to neomycin. Previous immunization is not a contraindication.	Women pregnant when immunized or who become pregnant within months of immunization should be counseled on the remote theoretical risks to the fetus. However, no risk of rubella vaccine-associated malformations in these women has been shown. MMR is vaccine of choice if recipients possibly are susceptible to measles or mumps as well as to rubella.
Polio Inactivated Virus Vaccine (IPV) or Live Virus Vaccine (OPV) or combination of IPV or OPV.	IPV: 2 doses 4-8 weeks apart; 3rd dose 6-12 months after 2nd. Dose: 0.5 ml (SC) OPV: 2 doses 6-8 weeks apart with a 3rd dose 6-12 months after the 2nd.	Personnel who may have direct contact with acute polio patients should complete a primary series. IPV series used for primary vaccination of persons age 18 years and older who have never received any polio vaccine before. For those partially immunized with OPV, complete the series with OPV or IPV.	• It is prudent on theoretical grounds to avoid immunizing pregnant women. • OPV should not be given to immunocompromised individuals or to persons with known immunocompromised family members. Use IPV in such situations. • Anaphylactic hypersensitivity to neomycin.	Although a protective immune response to IPV in the immunocompromised individual cannot be assured, the vaccine is safe and some protection may result from its administration.
Varicella Live Virus Vaccine	2 doses 4-8 weeks apart. Dose: 0.5 ml (SC)	Personnel who have regular or potential contact with immunocompromised patients, pregnant patients and/or others at increased risk for varicella complications. Persons who are seropositive or who have a convincing clinical history of varicella do not need immunization.	Immunocompromised; anaphylactic reaction to prior dose or to vaccine component; pregnancy; recent receipt of immune globulin or blood/blood product.	If apparent vaccine-induced rash occurs within 26 days after either dose, avoid room contact with immunocompromised, pregnant, or other high-risk persons for duration of rash.
Tetanus/Diphtheria	All adults, regardless of occupation, should receive Td (tetanus-diphtheria) toxoid boosters every 10 years. For those who have never received these toxoids, the primary immunization series with Td is 2 doses 4-8 weeks apart with a 3rd dose 6-12 months after the 2nd.			

* The vast majority of personnel born before 1940 are immune to measles, rubella, and mumps, but they can be immunized if there is uncertainty about their immunity status.
** For all of these vaccines, delay between doses does not require restarting series. Hepatitis A vaccine is not routinely recommended for health care workers.